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AUTHOR Stelmachers, Zigfrids T.; Sherman, Robert E.
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ABSTRACT

The clinical usefulness of various empirically derived suicide potential rating scales has been questioned by several suicidologists. This study used actual case histories in an attempt to anchor suicide risk ratings. Thirty-three brief case histories of suicidal patients were given to 19 experienced crisis workers for seven-point ratings of short- and long-term suicide risk. The ratings revealed considerable variability, raising questions about the reliability of such global assessments of suicidality. The most consistently rated cases were selected to operationally define "mild," "moderate," and "high" risk, making each level anchored by several vignettes. It is hoped that these anchor points will lead to more uniform and comparable ratings among crisis workers. The correlation between short- and long-term risk ranged from near zero to as high as .82, demonstrating the need to rate both separately. Long-term risk was more difficult to rate, as demonstrated by a larger number of cases judged to be unrateable because of "insufficient information." The findings have implications for both practice and future research. (Summaries of the case histories are appended.) (Author/NB)

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HOW USEFUL ARE SUICIDE RISK RATINGS?

Zigfrids T. Stelmachers, Ph.D.
Hennepin County Medical Center

Robert E. Sherman, Ph.D.
Hennepin County Office of Planning & Development

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ABSTRACT

Thirty-three brief case histories of suicidal patients were given to nineteen experienced crisis workers for seven-point ratings of short and long-term suicide risk. The ratings revealed considerable variability, raising questions about the reliability of such global assessments of suicidality. The most consistently rated cases were selected to operationally define "mild," "moderate," and "high" risk. Thus, each level is "anchored" by several vignettes. It is hoped that these anchor points will lead to more uniform and comparable ratings among crisis workers.

The correlation between short and long-term risk ranged from near zero to as high as .82, demonstrating the need to rate both separately. Long-term risk was more difficult to rate, as demonstrated by a larger number of cases judged to be unrateable because of "insufficient information" (96 versus 54 rater-case combinations).

Implications for practice and further research are discussed.

INTRODUCTION

The impetus for the current study came from various sources but mainly from a dissatisfaction with the day-by-day clinical utility of most suicide potential rating scales. The clinical usefulness of various empirically derived scales has been questioned by several suicidologists (Brown and Sheran, 1972; Litman, Farberow, Wold, and Brown, 1974; MacKinnon and Farberow, 1976; Motto, 1985).

Many of these rating scales are based on a prediction rather than assessment model, that is, the current suicide risk is derived by inference from the probability of a future event, such as a suicide attempt or suicide. And yet, it is well established that short-term prediction of individual suicidal behaviors is

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nearly impossible to achieve by the existing instruments (Pokorny, 1983). This is especially true if these prediction instruments are general purpose in kind, that is, supposed to be universally applicable to many different populations and settings. Some writers have correctly pointed out that rating scales, in order to be maximally useful, should be situation and setting specific (Brown and Sheran, 1972; Litman, Farberow, Wold, and Brown, 1974; Motto, 1985). The use of an actual suicidal event as a criterion of antecedent suicide risk is flawed, despite its easy measurability. Besides the ubiquitous base rate problem, we are faced with the fact that very high risk individuals sometimes miraculously survive suicide attempts and low risk persons end up committing suicide because of ignorance, poor judgment, and miscalculation. Also, those who eventually attempt or commit suicide may do so many years later in a state of mind and under circumstances which may have little relationship to the situation at the time suicide risk is being assessed. Furthermore, prediction is made difficult because the clinician working in a suicide prevention center typically has inadequate knowledge and control over such variables as precipitating events, opportunity to commit suicide, availability of the chosen method, and the effectiveness of intervening treatment.

Even our ability to make assessments is hampered by a lack of knowledge of how to assign proper weight to the known risk factors. It is, indeed, curious to see risk factors of vastly different clinical importance side-by-side within the same rating scale (typically empirically constructed), without this difference being formally recognized by some form of weighting system. Such items as sex, age, and season of the year are given the same weight as presence of mental disorder and being unconscious from a suicide attempt! (Tuckman and Youngman, 1968; Cohen, Motto, and Seiden, 1966.)

Even if such rating scales are used by suicide prevention centers and generate a cummulative score representing a certain level of suicide risk, the

typical clinician will, in most instances, utilize additional data outside the content of the rating scale. This leads to a subjective global suicide risk assessment based on all available information. As a matter-of-fact, the question has been raised regarding the relative utility of assessments based on rating scales as compared with clinical-global-subjective judgments, or integrated assessments based on both (Motto, 1977). To quote from Litman, Farberow, Wold, and Brown (1974): "...the scales should supplement but not replace the clinical judgment of people with experience in any particular setting." To the extent that clinical judgment is unavoidable, and perhaps even desirable, the use of suicide potential rating scales may represent a certain danger of misapplication if they fall into the wrong hands. It is seductive for individuals without mental health training to have available to them easily scorable scales which can be applied in a rather mechanical fashion. Unless such scales are applied in a strictly initial screening function, such nonclinical use could lead to faulty treatment plans and dispositions. The assumption made here is that the risk ratings make a real difference, that "mild risk" clients may get outpatient counseling while those with "high risk" may be involuntarily admitted to a locked psychiatric ward.

(Insert Table 1 - Suicide Risk Levels Matched with Suggested Intervention Strategies)

Table 1 illustrates an attempt to match various levels of suicide risk, as exemplified by rationally constructed case vignettes, with proposed intervention strategies. The purpose of this table is to emphasize the dimensional nature of suicidality and the feasibility of attaching appropriate clinical dispositions to the various risk levels.

While useful to illustrate a point, it has several shortcomings. One is that the vignettes do not represent real people. Another one is that one can obviously arrive at the same level of risk through very different "packages"

of risk factors. Also, various interventions may not be possible in certain settings (such as tracing phone calls, legal holds, seclusion, etc.). Finally, depending on the base rates of significantly suicidal individuals in a given clinic or center, there may be substantial disagreement as to what constitutes "mild" as opposed to "moderate" suicide risk. (This, by the way, demonstrates even further the relative nature of such ratings.)

Because of the above limitations, clinical judgments of suicide risk tend to be rather unreliable. It has been found in previous studies that significant disagreements exist over ratings between judges and for the same judges over time (Wittemore, 1968). The current study attempts to use actual case histories to anchor suicide risk ratings. This is somewhat analogous to the scoring system used by the Weschler Adult Intelligence Scale which provides examples of "0," "1," and "2" scores. The intent is to guide the scorer and to make scores more comparable from test to test.

Such anchoring points would also serve as a sort of dictionary translating the "language" of one agency or crisis worker to that of another. Thus, the operational meaning of "moderate" risk would be explicated by the corresponding vignettes.

METHOD

Thirty-three charts were randomly selected from a crisis intervention center's active files. Only those charts were selected which contained a recent global suicide risk rating. Three groups of eleven cases each were chosen to represent "mild," "moderate," and "high" suicide potential. The senior author then summarized the record attempting to include most of the data relevant to the assessment of suicide risk. Since the information was gathered as part of crisis intervention visits, it was often rather scant and the content varied from case to case.

The case summaries were then given to nineteen crisis workers for 7-point

short-term and long-term suicide risk ratings. The staff were given the following instructions:

> As you may have guessed, our risk ratings are quite variable, with only moderate correlation between ratings of individual staff members. The following is an attempt to anchor down risk ratings in order to achieve a greater uniformity in our suicide assessment.
>
> These vignettes are extracts from patient case histories. The data represent information which was felt to be relevant, <u>at the time of contact</u>, for arriving at a global risk assessment. The vignettes vary in length, comprehensiveness, and content covered; this reflects not only my selection but also the particular content elicited from the patient by our staff. The vignettes represent all levels of suicide risk from low to high.
>
> You are asked to indicate your personal rating for each of the vignettes on a 7-point scale. Try to use the entire range of ratings instead of bunching them up in the middle. It may be helpful to read through all the vignettes first and then go back to the individual ratings. If you feel the information provided is not sufficient for a rating, please indicate so. Please do not consult with your colleagues regarding your ratings as this would confound the results.

The raters were very experienced mental health professionals and a few mental health workers. Eleven of the nineteen had ten or more years' experience at the crisis intervention center; five had two years' or less experience at the center, but all of them had considerable previous experience in psychiatric settings.

RESULTS

(Insert Table 2 - Summary of Suicide Risk Ratings on 33 Case Vignettes)

Table 2 provides a summary of suicide risk ratings on thirty-three case vignettes. The following vignettes were selected to represent three scale points (see Appendix for the actual vignettes):

	Short-term Risk	Long-term Risk
Low	Vignettes 1, 4, 11, 14, 26	Vignettes 4, 14, 26
Moderate	Vignettes 17, 20, 27, 31, 33	Vignettes 2, 5, 8, 28
High	Vignettes 2, 3, 7, 13, 19	Vignettes 9, 13, 19, 29

(Insert Table 3 - Standard Deviations of Rater Normalized Suicide Risk Ratings)

Since the regular and rater normalized ratings were rather similar, both were utilized in the selection of the case histories. An attempt was made to use case summaries whose means were closest to scale points 1, 4, and 7 (to correspond to low, moderate, and high risk). Vignettes with the smallest standard deviations were preferred for obvious reasons. Also, some case summaries were eliminated because they were felt to be unrateable by too many of the raters.

(Insert Table 4 - Average Suicide Risk Ratings by Staff Rater)

The following results are worth noting:

1. There is considerable and disconcerting variability among staff ratings.

2. The variability, as measured by the standard deviation, is comparable between short-term and long-term risk ratings.

3. The correlations between short and long-term risk ratings range from near 0 to as high as .82, reinforcing the need for separate ratings in these two categories.

(Insert Table 5 - Short and Long-term Rater Normalized Suicide Risk Ratings for 33 Case History Vignettes)

4. The range of ratings for long-term risk is more "compressed" than for short-term risk ratings. It seems that the raters felt less sure about the long-

term risk ratings and though the variability of the ratings remained high, the average ratings tended to bunch closer to the middle.

(Insert Table 6 - Means of Suicide Risk Ratings for Selected Vignettes)

5. The standard deviation for the ratings of short-term high risk vignettes was considerably smaller than the standard deviations for mild and moderate short-term risk ratings. This suggests that there was much better agreement among raters for high risk cases.

6. The mean rating for mild long-term risk nearly reached 3 on a 7-point scale. This indicates raters' reluctance to assign low ratings for long-term risk.

7. Certain crisis workers tend to rate consistently high or low across vignettes and also tend to differ considerably on the spread of their ratings. For short-term risk, the mean ratings range from 3.25 to 5.61 (SDs from 1.00 to 2.16); for long-term risk, the range of means was 1.81 to 5.86 (SDs from .98 to 1.69). The following graphs show three crisis workers' ratings illustrating different response patterns.

(Insert Table 7 - Different Response Patterns by Three Selected Raters)

8. Staff also differed significantly in their willingness to rate the case histories. Some found all vignettes rateable while others rejected as many as 10. Again, long-term risk was harder to rate as judged by the higher mean number of rejections (5.1 versus 2.8 for short-term risk). Vignettes 16, 18, 24, and 30 were rejected by most staff as unrateable for both short and long-term risk. The common element in the content of these vignettes was the staff inability to complete a comprehensive evaluation at the time of the crisis visit because the patient was intoxicated, uncooperative, incoherent, or otherwise difficult to interview.

9. Somewhat predictably, the sex differential in terms of suicide risk

came through very clearly in the final selection of vignettes. All short-term low risk patients were female, all but one of the short-term high risk patients were male, and the short-term moderate risk category occupied a middle position in respect to the male/female ratio.

DISCUSSION

Global judgments about suicide potential are made everyday in hundreds of crisis intervention and suicide prevention centers, whether they are made with the help of additional, more objective measures or not. These assessments have significant consequences for the persons being judged. And yet, quite experienced and, for the most part, professionally educated and trained crisis workers do not show much agreement in their ratings, except for short-term high suicide risk. It is perhaps somewhat reassuring that at least for this high risk group our judgments show more uniformity and, hopefully, lead to appropriate clinical decisions. The meaning and implications of lower risk ratings and long-term risk ratings are less certain.

It is hoped that by establishing empirically derived descriptive anchoring points for various levels of suicide risk, reliability of ratings will be improved, but this has not been subjected to a test.

The study has obvious shortcomings: the numbers of case histories and raters are rather small; the case histories were summarized by one individual using subjective judgment in the selection of relevant clinical material; the standard deviations for the finally chosen vignettes are still substantial; we do not know which content of the case histories determined the ratings; the case summaries were quite brief and the kind of clues one may observe in face-to-face situations were naturally not available to the raters; and, above all, the issue of validity was not addressed (considering the already discussed obstacles to short-term individual prediction of suicidal behavior, it is perhaps unfortunate that most studies addressing validity of various rating scales have emphasized

predictive validity).

One thing not done was to check time-to-time reliability within the same rater. It is quite possible that raters could agree with their own previous ratings as little as with the ratings of their colleagues.

Another interesting refinement would be to correlate case histories directly with clinical dispositions, avoiding intervening judgments of suicide risk. This would be particularly promising considering the poor reliability of global risk ratings. There are only a limited number of dispositions available to most crisis centers: release, refer, hospitalize (on a locked ward, on general or strict suicide precautions), trace phone call, send police and/or ambulance, place patient on a legal hold, support involuntary commitment, keep patient for overnight observation, etc.

In the meantime, one has to exercise caution in accepting the value and utility of global ratings of suicide risk. As pointed out earlier, the same is true of ratings derived from empirically constructed predictive instruments. We will probably continue using such subjective global ratings, despite the current findings, because it is generally expected of us and because to make such judgments seems like a very natural and obvious thing to do. At the very least, however, we should be painfully conscious of the fact that we are making rather unreliable assessments of suicide risk, which is a far cry from making valid predictions of suicidal behavior.

TABLE 1

SUICIDE RISK LEVELS MATCHED WITH SUGGESTED INTERVENTION STRATEGIES

LEVEL OF RISK	VIGNETTE ELEMENTS	INTERVENTION
Low	- Situation adjustment problems; desire to sleep and not wake up; no plan or method for suicide selected; no psychiatric history or current mental illness; no previous suicide attempts; no significant depressive symptoms; current stress of moderate proportions.	Provide opportunity to talk about the situational problems; encourage sharing of feelings with significant others; explore need for further evaluation and ongoing counseling by mental health professionals.
Mild	- Mildly intoxicated, frustrated, and angry; recent rejection experience; mildly depressive mood mixed with self pity; motive for suicide is to hurt someone or influence a significant other's behavior; suicide plan involves a relatively nonlethal method, such as cutting wrists; history of alcoholism, impulse control problems and suicide threats but no attempts.	Client needs to sober up (verbal intervention of limited effectiveness); check reality of client's perception of rejection; the "rejecting" significant other may be brought in if attitude is supportive and helpful; consider chemical dependency treatment if history reveals that suicide risk is elevated during periods of intoxication.
Moderate	- Recent loss of parent/child/spouse; client significantly depressed with sleep and eating disturbance; expresses hopelessness about future; previous suicide attempts and psychiatric treatment; has suicide planned, but selected method not currently available; cooperative.	Requires immediate professional attention, including evaluation of need for medications and/or hospitalization; prevent isolation; have client go to a mental health professional or reconnect client to previous therapist.
High	- Client demonstrates lack of adequate reality contact and may be psychotic; admits to having a definite suicide plan but won't reveal it; has written a suicide note and chosen a time and place for suicide.	Encourage client to come immediately to a hospital/emergency room/mental health center; make sure client gets there; involve others in accomplishing this, if necessary; if client does not arrive, more drastic measures may be necessary.
Imminent	- Client has a gun and ammunition, is alone at home, and threatens to kill self tonight; uncooperative with suggestions for rescue.	Trace phone call and keep client on the phone (if contact was made by phone); send ambulance/police to bring client to a hospital emergency room or crisis intervention center; this may be done coercively on the basis of a legal hold.

TABLE 2

SUMMARY OF SUICIDE RISK RATINGS ON 33 CASE VIGNETTES

(N = 19 CIC STAFF)

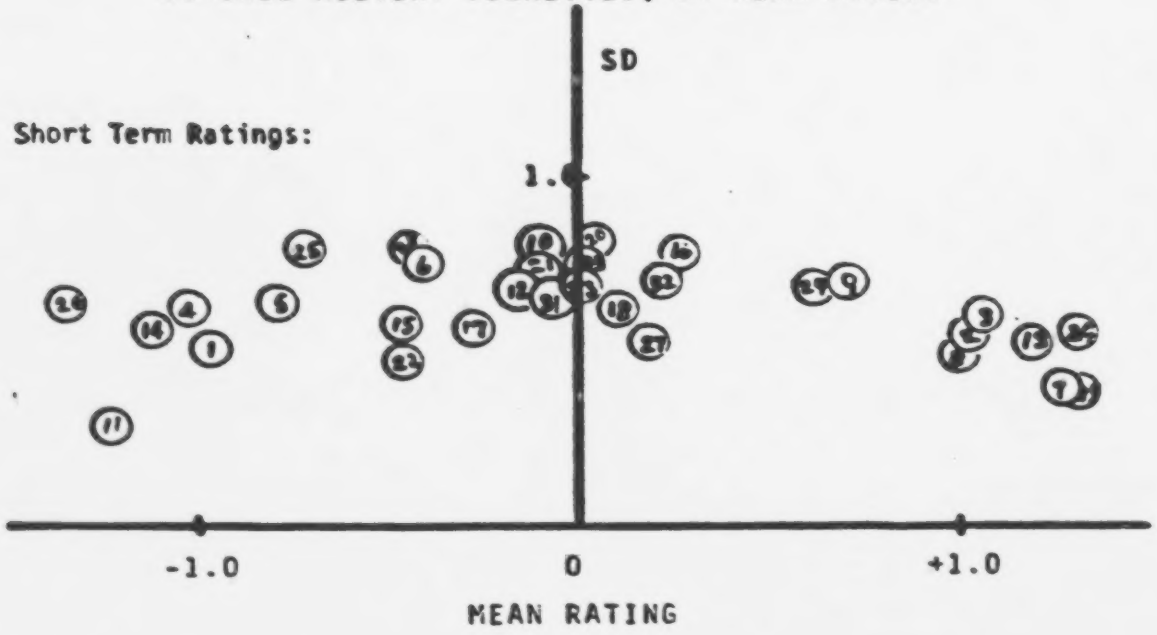
VIGNETTE NUMBER	SHORT TERM			LONG TERM			RHO, SHORT, LONG	SIG. OF RHO
	N	MEAN	SD	N	MEAN	SD		
1	14	2.79	1.42	12	3.58	1.31	0.11	0.37
2	19	6.11	1.10	16	4.44	1.32	0.55	0.01
3	19	6.21	0.86	17	5.29	1.12	0.52	0.02
4	19	2.79	1.44	19	3.16	0.96	0.03	0.46
5	19	3.31	1.20	19	4.11	1.49	0.69	0.00
6	17	3.77	1.64	17	5.23	1.68	0.48	0.03
7	19	6.47	0.70	18	5.00	1.53	0.33	0.09
8	19	6.11	0.88	19	4.47	1.07	0.12	0.31
9	17	5.64	1.32	17	5.53	1.23	0.44	0.04
10	19	4.42	1.43	19	4.00	1.33	0.53	0.01
11	19	2.52	1.02	19	3.84	1.50	0.53	0.01
12	19	4.21	1.32	19	4.84	1.50	0.38	0.05
13	19	6.47	0.70	19	6.11	0.94	0.52	0.01
14	19	2.68	1.29	19	3.32	1.64	0.26	0.14
15	19	3.68	1.46	18	3.83	1.47	0.74	0.00
16	13	5.00	1.41	6	4.00	1.41	0.82	0.02
17	19	4.05	1.31	19	3.90	1.66	0.67	0.00
18	13	4.77	1.09	8	4.13	0.99	0.27	0.26
19	19	6.58	0.61	18	5.50	1.54	0.68	0.00
20	19	4.53	1.26	19	4.68	1.64	0.62	0.00
21	19	4.26	1.22	19	4.63	1.95	0.71	0.00
22	17	3.77	1.03	17	3.71	1.36	0.75	0.00
23	18	4.33	1.61	16	4.88	1.26	0.65	0.00
24	12	5.83	0.94	4	4.75	0.50	0.26	0.37
25	19	3.42	1.50	18	3.56	1.46	0.75	0.00
26	16	2.25	1.29	13	2.39	1.19	0.30	0.16
27	19	4.68	1.20	19	4.37	1.30	0.18	0.22
28	19	3.74	1.66	19	4.26	1.52	0.40	0.04
29	19	5.47	1.07	18	5.61	1.15	0.35	0.08
30	2	4.50	0.71	1	2.00			
31	19	4.32	1.25	19	4.63	1.26	0.18	0.23
32	18	4.78	1.26	18	3.72	1.32	0.17	0.25
33	18	4.50	1.30	15	3.80	1.21	0.15	0.29

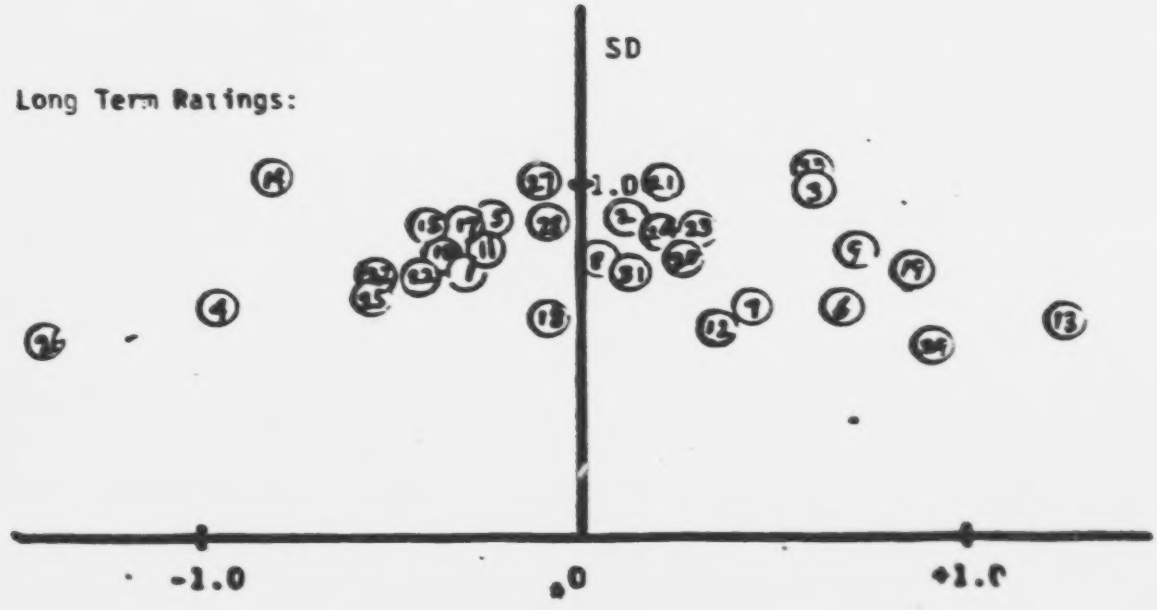
TABLE 3

STANDARD DEVIATIONS of RATER-NORMALIZED SUICIDE RISK RATINGS

for

33 CASE HISTORY VIGNETTES, BY MEAN RATING





(Circled numbers identify vignettes)

TABLE 4

AVERAGE SUICIDE RISK RATINGS

BY STAFF RATER

Staff	-- Short Term Risk -- Mean	SD	N	--- Long Term Risk -- Mean	SD	N
1	4.56	1.65	27	5.22	1.40	27
2	5.17	1.00	29	4.00	1.04	27
3	4.36	1.46	33	4.47	1.63	32
4	5.03	1.28	31	5.10	.98	29
5	5.61	1.09	31	4.10	.98	31
6	3.84	1.90	32	3.50	1.52	32
7	5.03	1.31	32	4.17	1.17	24
8	4.65	1.25	31	4.64	1.34	28
9	5.29	1.97	31	5.76	1.16	25
10	4.00	1.71	31	3.87	1.20	31
11	4.36	1.42	28	5.86	1.15	28
12	3.81	2.07	31	4.89	1.34	28
13	4.13	1.98	31	3.65	1.50	31
14	3.28	1.89	32	1.81	1.69	27
15	5.50	1.20	30	5.00	1.29	25
16	3.75	2.16	32	4.14	1.41	28
17	4.00	1.50	25	4.52	1.38	23
18	4.00	1.70	28	3.96	1.32	28
19	4.90	1.54	29	4.76	1.38	29

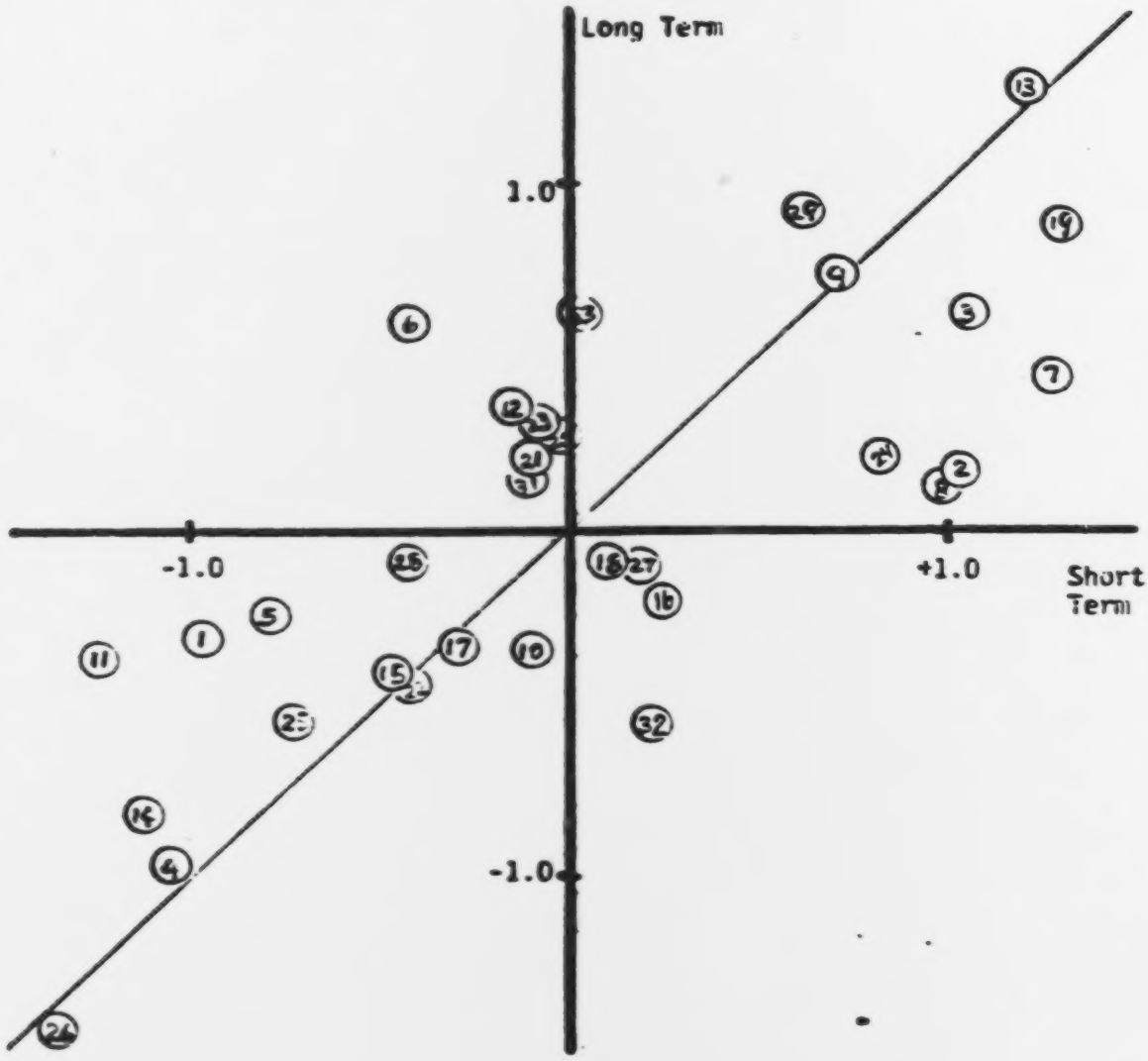
TABLE 5

AVERAGE

SHORT AND LONG TERM RATER-NORMALIZED SUICIDE RISK RATINGS

for

33 CASE HISTORY VIGNETTES

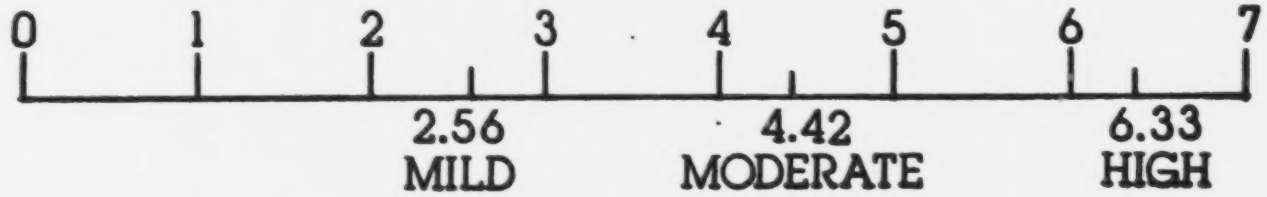


(Circled numbers identify vignettes)

TABLE 6

Means of Suicide Risk Ratings for Selected Vignettes

Short Term Risk



Long Term Risk

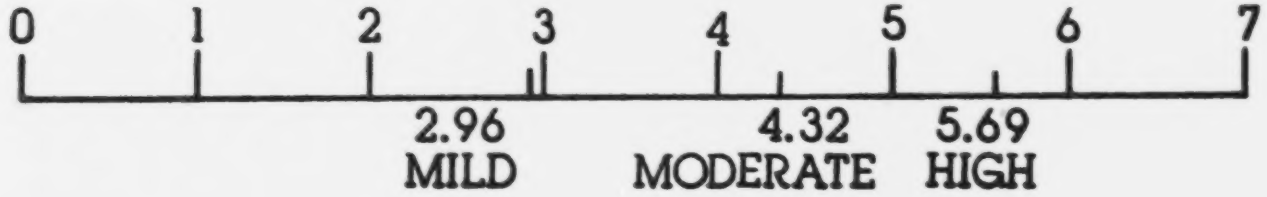
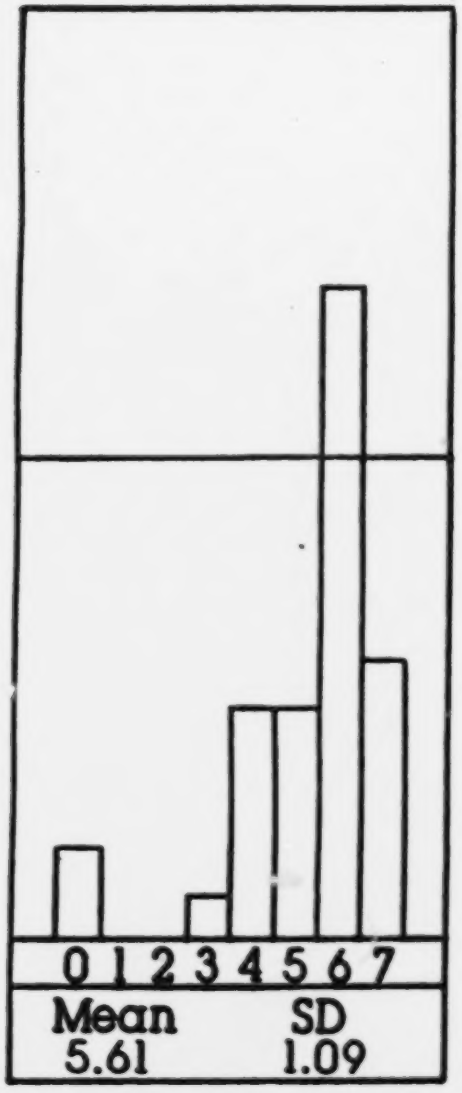


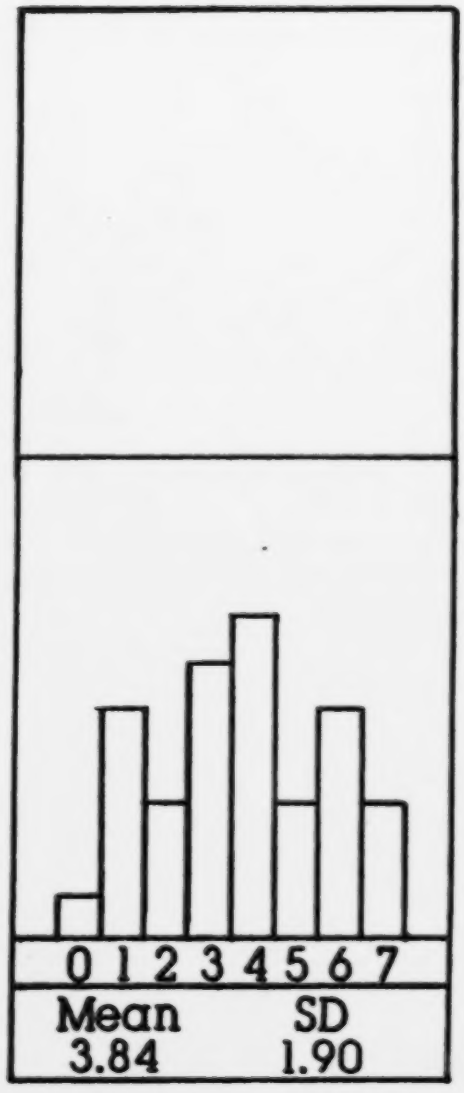
TABLE 7

SHORT TERM RISK RATINGS:

Different Response Patterns by Three Selected Raters.



Rater "D"



Rater "M"

Rater "H"

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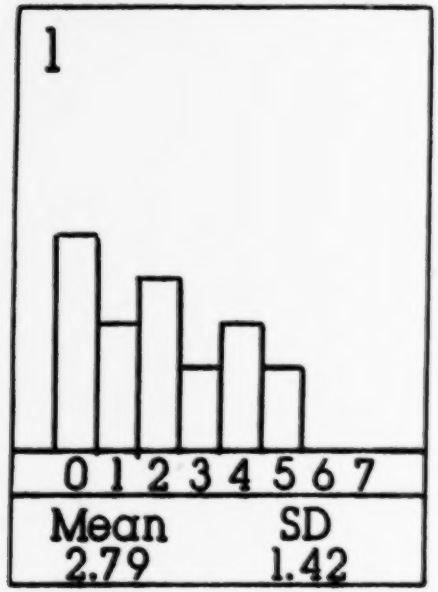
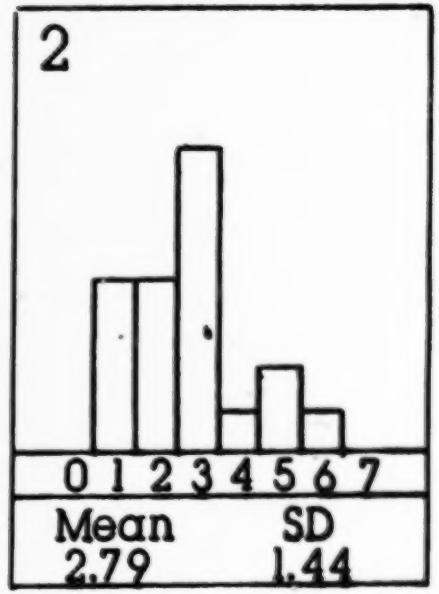
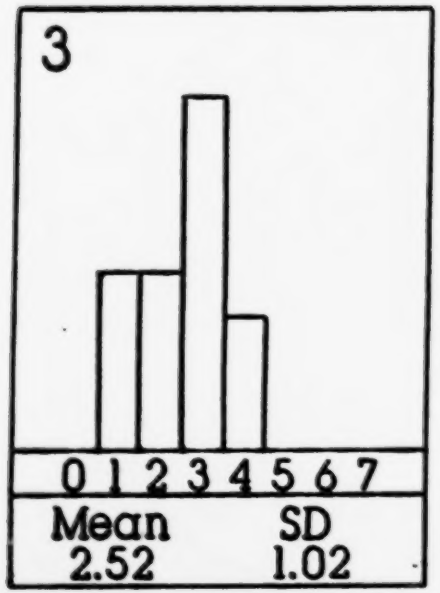
APPENDIX

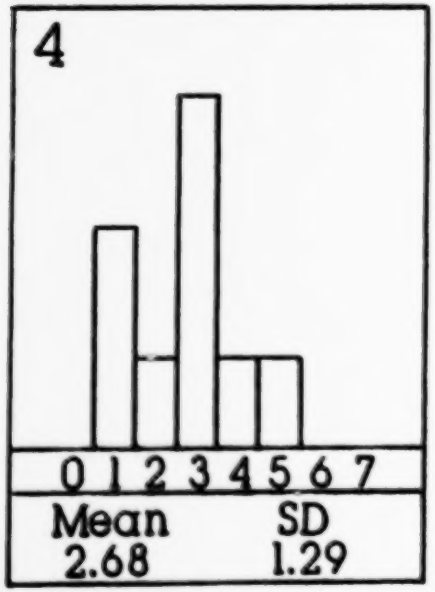
SHORT TERM RISK

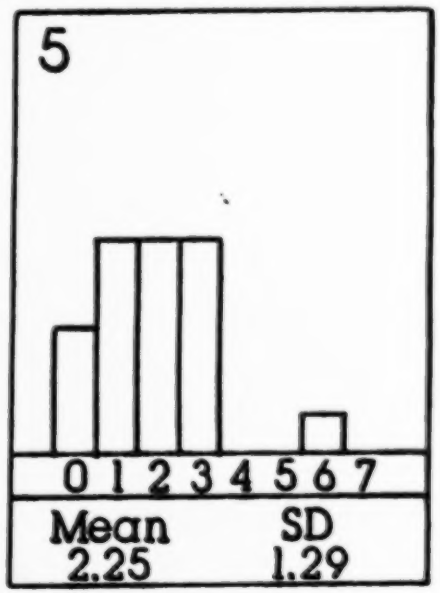
Low





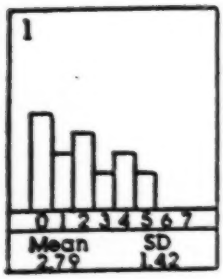




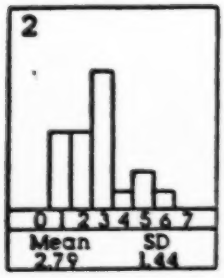


SHORT TERM RISK

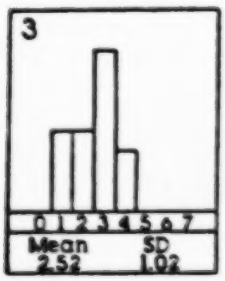
Low



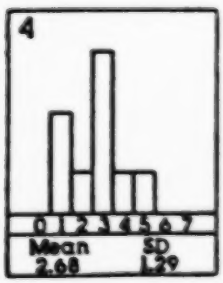
26-year-old female phoned her counselor, stated that she "might take pills," then hung up and kept phone off the hook. Counselor called police, and patient was brought to CIC on a transportation hold. Patient angry, denies suicidal intent, refused evaluation. Described as "selectively mute." Diagnostic impression: dependent and/or borderline personality.



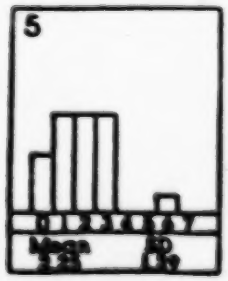
37-year-old female, self-referred. Stated plan is to drive her car off a bridge. Precipitant seems to be verbal abuse by her boss; after talking to her nightly for hours, he suddenly refused to talk to her. As a result, patients feels angry and hurt, threatened to kill herself. She is also angry at her mother who will not let patient smoke or bring men to their home. Current alcohol level is .15, patient is confused, repetitive and ataxic. History reveals a previous suicide attempt (overdose) seven years ago which resulted in hospitalization. After spending the night at CIC and sobering, patient denies further suicidal intent.



17-year-old Native American female, referred from a detoxification center for an evaluation of suicide risk. Patient lacerated her wrist with a piece of glass while intoxicated. Now regrets the attempt and denies being suicidal. Has been depressed for approximately 1 month, but there are no vegetative signs of depression. Self-esteem is impaired, however. Recent loss of boyfriend and has difficulties coping with it; did not finish school and is unable to provide for herself. There is one previous suicide attempt exactly 1 year ago (cut wrist); this attempt also occurred following the loss of a boyfriend. Patient is dependent on alcohol and marijuana and has had chemical dependency treatment in the past. She also received one month of counseling following the previous suicide attempt. Diagnostic impression: atypical depression.



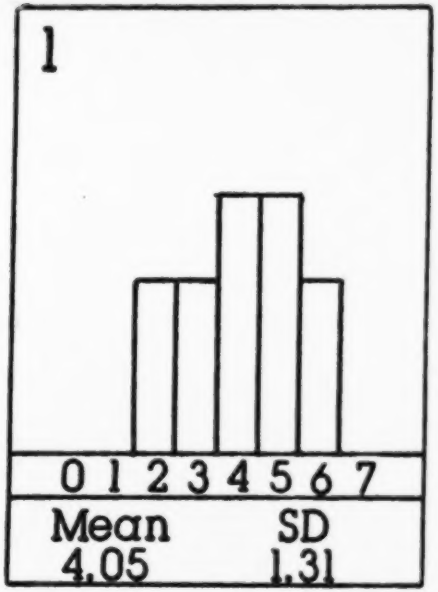
19-year-old female, Native American, referred from the Emergency Room with lacerations on both forearms requiring 26 stitches. Patient calls her suicide attempt a "mistake" and a "gesture." Denies being depressed and having any further suicidal impulses ("It's not worth it"). Precipitant: argument with boyfriend (jealousy). Patient cut herself "to hurt him." Patient is cooperative in the interview, and her cousin confirms the patient's story.

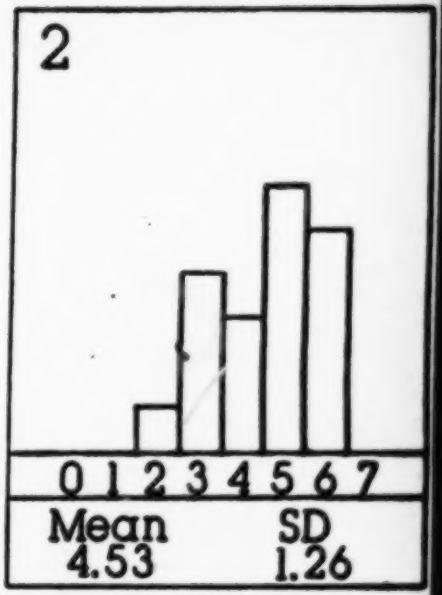


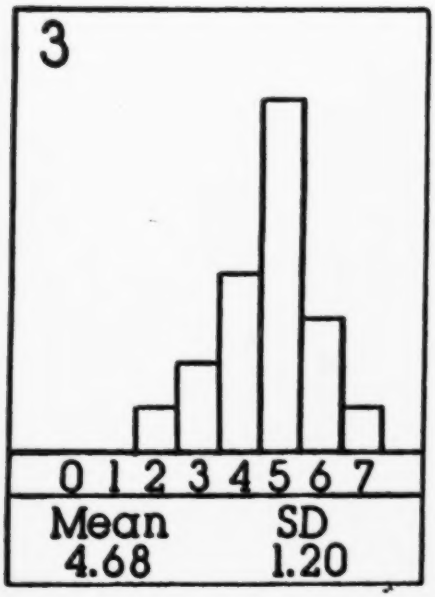
16-year-old Native American female, self-referred following an overdose of 12 aspirin. Precipitant: could not tolerate rumors at school that she and another girl are sharing the same boyfriend. Denies being suicidal at this time ("I won't do it again, I learned my lesson"). Reports that she has always had difficulty expressing her feelings. In the interview is quiet, guarded, and initially quite reluctant to talk. Diagnostic impression: adjustment disorder.

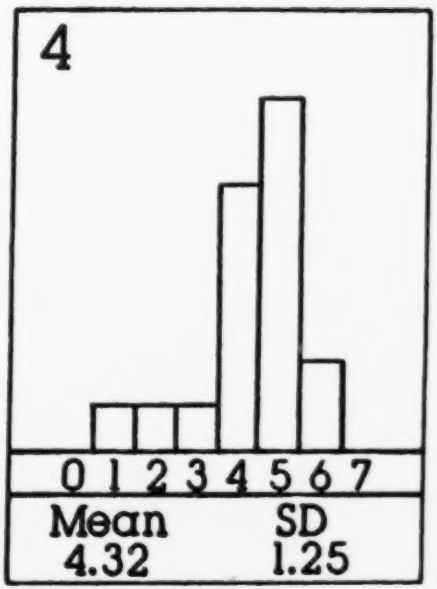
SHORT TERM RISK

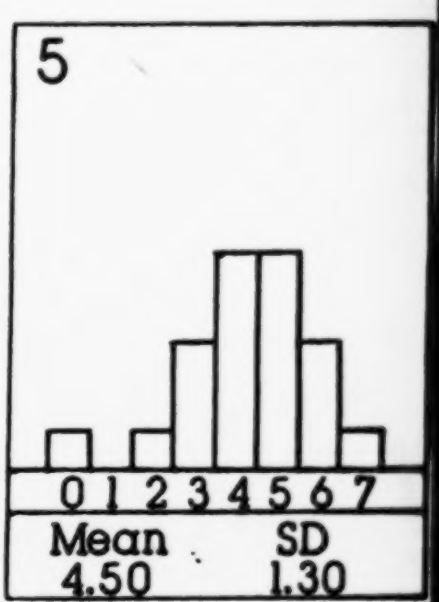
Moderate



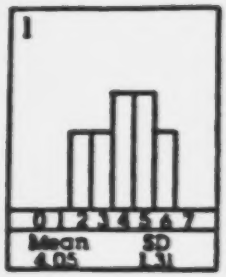




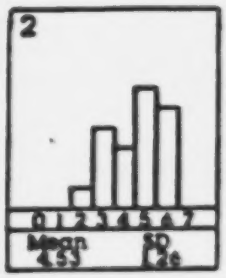




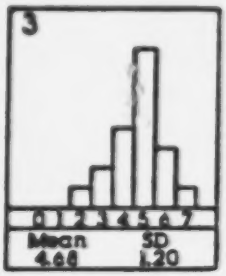
SHORT TERM RISK Moderate



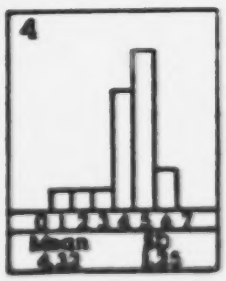
49-year-old female brought by police on a transportation hold following threats to overdose on aspirin (initially telephoned CIC and was willing to give her address). Patient feels trapped and abused, can't cope at home with her schizophrenic sister. Wants to be in the hospital and continues to feel like killing herself. Husband indicates that the patient has been threatening to shoot him and her daughter but probably has no gun. Recent arrest for disorderly conduct (threatened police with a butcher knife). History of aspirin overdose three years ago. In the interview, patient is cooperative, appears depressed, anxious, helpless, and hopeless. Appetite and sleep are down and so is her self-esteem. Is described as "anhedonic." Alcohol level: .12.



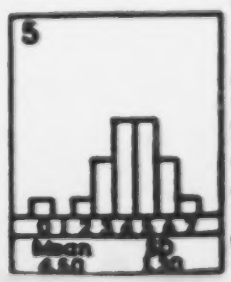
27-year-old Cambodian female called the suicide line after ingesting 20 sleeping pills last night. Following the ingestion, she inducted vomiting, slept until morning, and then called CIC. Patient still feels suicidal, refused to give identifying information. Phone call was traced and police brought the patient to CIC. Patient still feels frustrated and hopeless, states that the attempt was impulsive. Stress: has been recently fired from her job, break up with boyfriend, and chronic painful back injury. Patient was pregnant by her boyfriend and had a recent abortion. He has abused her physically. There is a history of 2 previous suicide attempts, one at age 18, the other 18 months ago. Currently in treatment in two groups (one of them for sexual assault). Poison Control Center informed CIC that patient is medically safe.



23-year-old male, self-referred. Patient bought a gun 2 months ago to kill himself and claims to have the gun and 4 shells in his car (police found the gun but no shells). Patient reports having planned time and place for suicide several times in the past. States that he cannot live anymore with his "emotional pain" since his wife left him 3 years ago. This pain has increased during the last week, but the patient cannot pinpoint any precipitant. Patient has a history of chemical dependency but has been sober for 20 months and currently goes to AA. There is one previous psychiatric admission. During the marriage, the patient beat his wife severely several times a week. She is currently in another relationship and little likelihood of returning to the patient. In the interview, patient appears depressed and irritable. Is angry, hostile, and threatening ("You bitch, I hate women"). Reports no sleep or appetite disturbance.



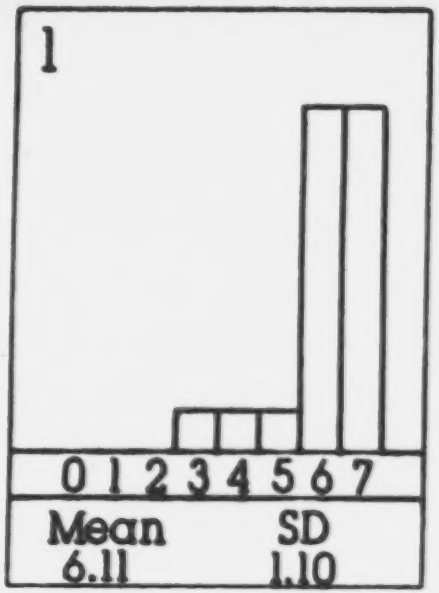
22-year-old black male referred to CIC from the Emergency Room on a transportation hold. He referred himself to the Emergency Room after making fairly deep cuts on his wrists requiring 9 stitches. Current stress is recent break up with his girlfriend and loss of job. Has developed depressive symptoms for the last 2 months, including social withdrawal, insomnia, anhedonia, and decreased appetite. Blames his sister for the break up with girlfriend. Makes threats to sister ("I will slice up that bitch, she is dead when I get out"). Patient is an alcoholic who just completed court-ordered chemical dependency treatment lasting 3 weeks. He is also on parole for attempted rape. There is a history of previous suicide attempts and assaultive behavior which led to the patient being jailed. In the interview, patient is vague regarding recent events and history. He denies intent to kill himself but admits to still being quite ambivalent about it. Diagnostic impression: antisocial personality.

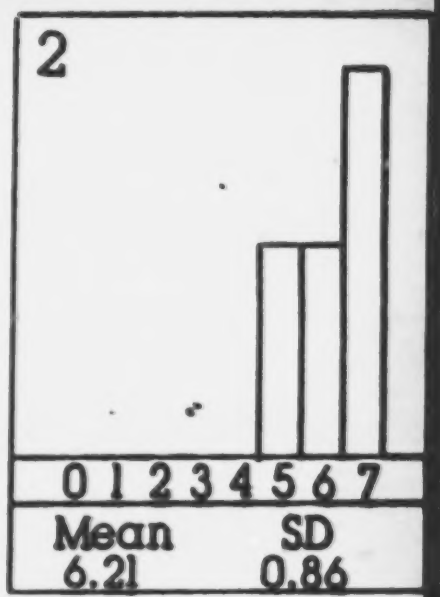


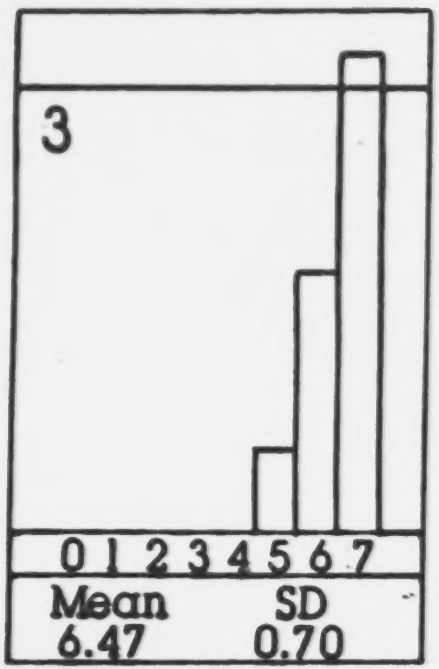
24-year-old female brought by police on hold. Patient was found "hanging from a bridge." Precipitant was an argument with her husband. Has been married for 9 months, relationship is abusive with daily arguments, and pulling each other's hair. Patient just hitchhiked here from Florida. Patient states that "If I can't be with my husband, I don't want to live." In the interview is described as impulsive, immature, histrionic, angry, hostile, and demanding. Shouts at the interviewer. Also appears to have low self-esteem. Diagnostic impression: mixed personality disorder.

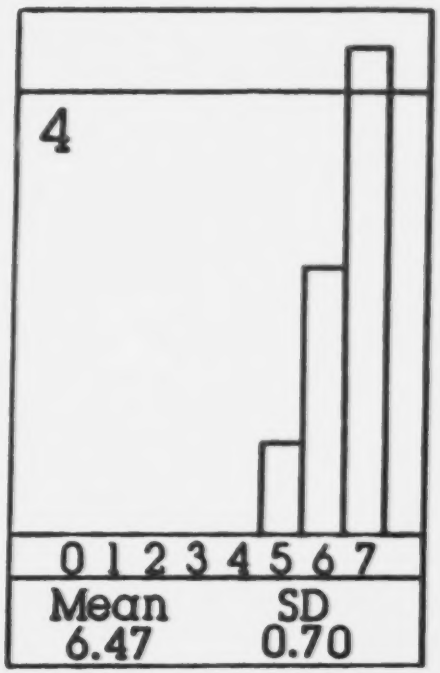
SHORT TERM RISK

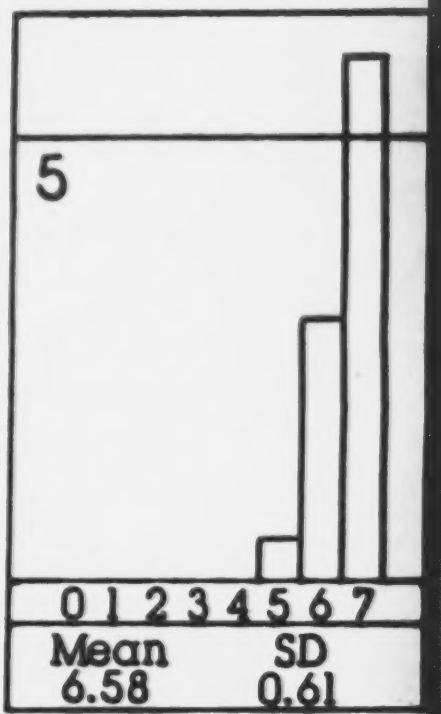
High



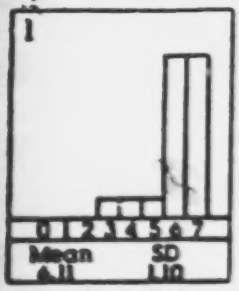




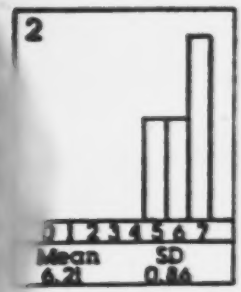




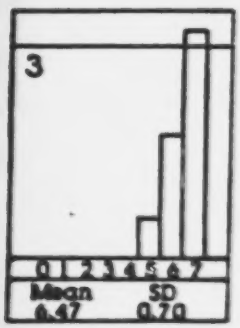
SHORT TERM RISK High



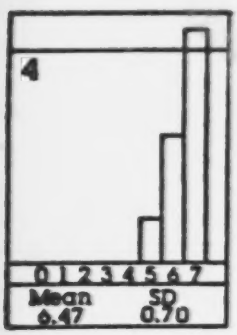
19-year-old male found by roommate in a "sluggish" state following the ingestion of 10 sleeping pills (Sominex) and 1 bottle of whiskey. Recently has been giving away his possessions and has written a suicide note. After being brought to the Emergency Room, declares that he will do it again. Blood alcohol level .23. For the last 3 or 4 weeks there has been sleep and appetite disturbance, with a 15-pound weight loss and subjective feelings of depression. Diagnostic impression: adjustment disorder with depressed mood versus major depressive episode. Patient refused hospitalization.



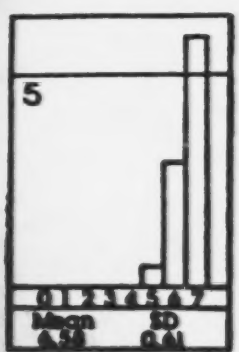
21-year-old male, foreign graduate student, brought to CIC by friends and pastor. After informing his friends that he planned to jump off a bridge, he actually went there and had to be physically restrained from jumping. Had written several suicide notes, one willing his computer to a friend, another to a different friend stating that the patient will be dead by the time his note would be opened. Describes himself as being quite depressed, with low energy, poor sleep and appetite, and persistent suicidal ideation. Precipitant seems to have been his girlfriend breaking off their engagement 4 days ago. He has a psychiatric history of several years but refuses to reveal details about it. Exhibits some grandiosity, paranoid mentation, anger, agitation, and irritability. Appears to be somewhat manic but not depressed. Denies acute plan to commit suicide and is threatening to sue CIC for being detained.



25-year-old male referred from the Emergency Room following a suicide attempt with gas and strangulation. Patient turned on the gas and tied a towel around his neck until he turned blue and passed out. His roommate was present while he turned on the gas. Emergency Room classifies this medically as a high lethality suicide attempt. At CIC patient maintains that he will still hang himself, given the opportunity. Precipitant seems to be the patient finding out 1 week ago that his girlfriend was dating his friend. Other stressors include a recent move, financial problems, and being on probation at work for absenteeism. History reveals an overdose at the age of 15, which led to psychiatric hospitalization. Diagnostic impression: adjustment disorder with depression, plus questionable alcohol abuse.



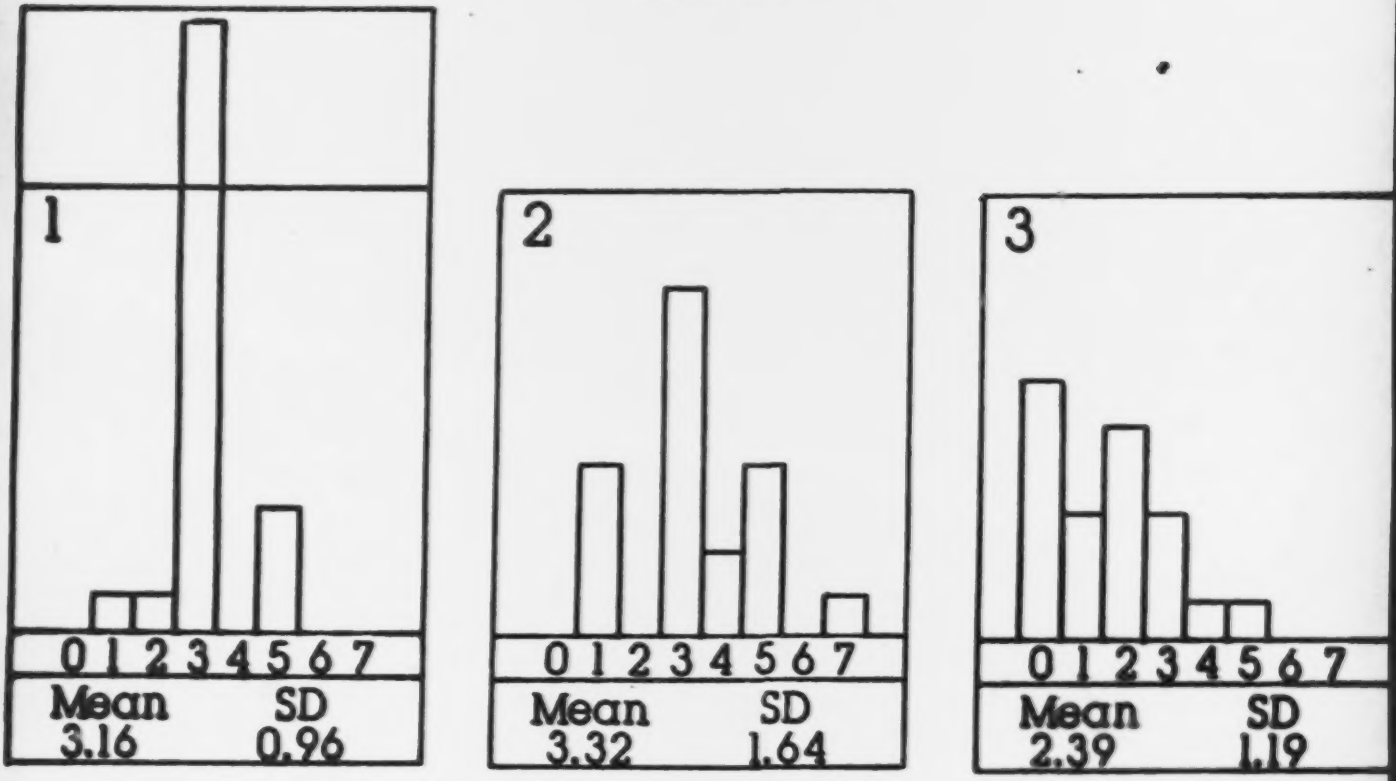
30-year-old male brought from his place of employment by a personnel representative. Patient has been thinking of suicide "all the time" because he "can't cope." Has a knot in his stomach, sleep and appetite are down (sleeps only 3 hours per night), and plans to either shoot himself, jump off a bridge, or drive recklessly. Precipitant: constant fighting with his wife leading to a recent break up (there is a long history of mutual verbal/physical abuse). There is a history of a serious suicide attempt: patient jumped off a ledge and fractured both legs; the precipitant for that attempt was a previous divorce. There is a history of chemical dependency with 2 courses of treatment. There is no current problem with alcohol or drugs. Patient is tearful, shaking, frightened, feeling hopeless, and at high risk for impulsive acting out. He states that life isn't worthwhile.



32-year-old male referred from the Emergency Department. Patient was in the process of overdosing when was called by a friend, who arranged for the ambulance to bring patient to CIC. The patient took 72 over-the-counter sleeping pills and 10 or 15 aspirin tablets. Patient wrote a long suicide note bequeathing belongings, expressing guilt about not doing well on his job, feeling hopeless about a "hereditary thinking disorder." Feels that no one can help him, suffers from low self-esteem ("I'm a misfit"). Three nights ago made a suicide attempt with Havana and aspirin but woke up by himself in the morning. Lives by himself. No obvious immediate precipitant, but the patient's mother died 6 months ago. Currently in therapy and also has a psychiatrist.

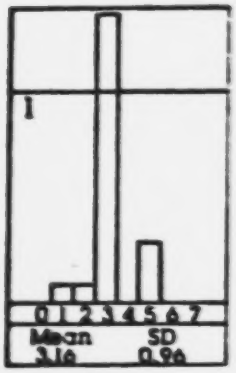
LONG TERM RISK

Low



LONG TERM RISK

Low



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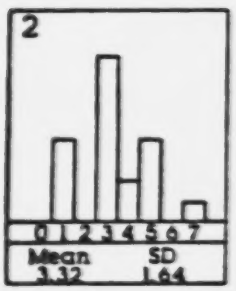

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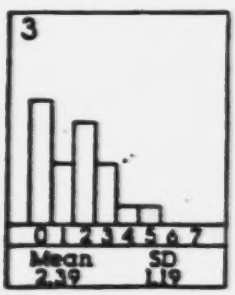

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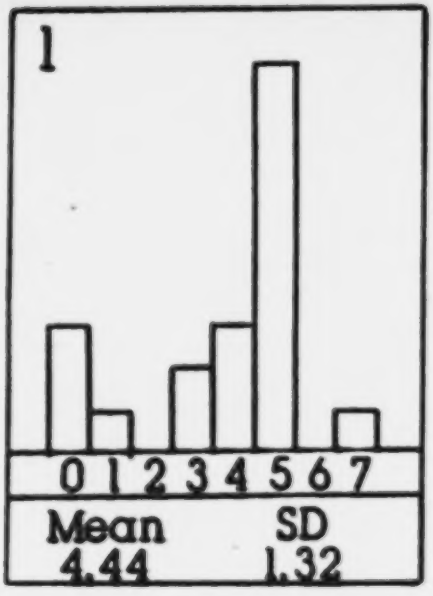
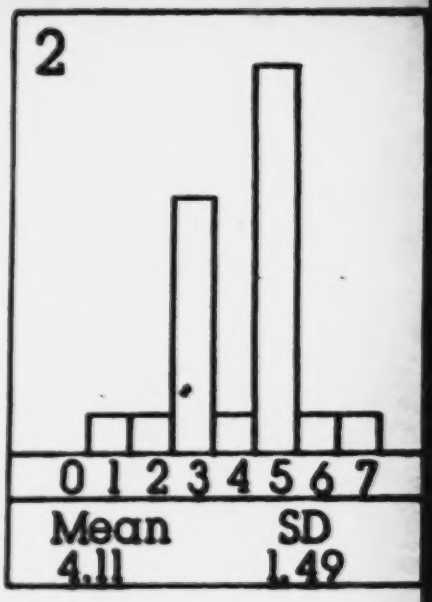
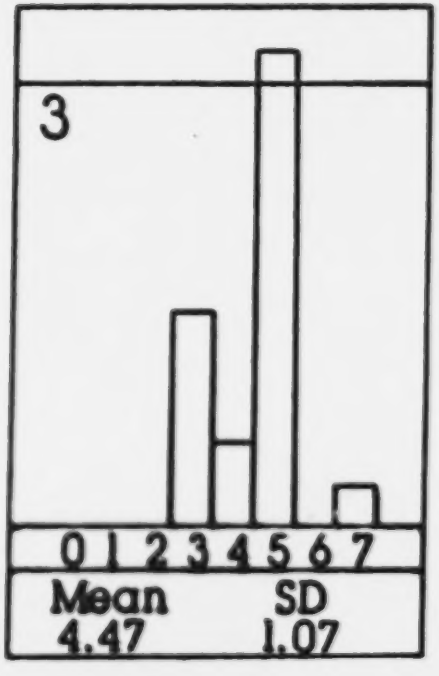
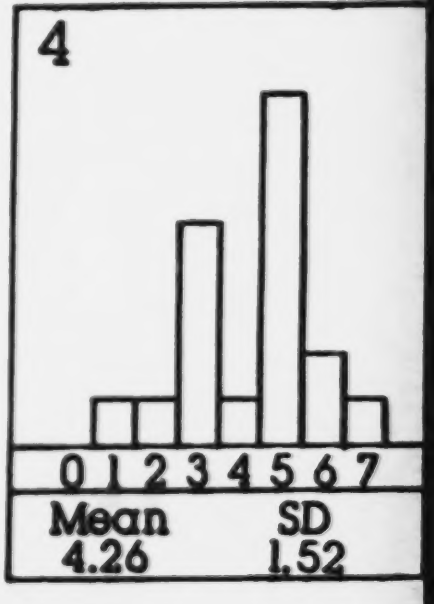
LONG TERM RISK

Moderate



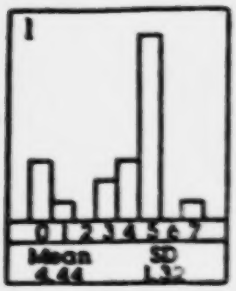




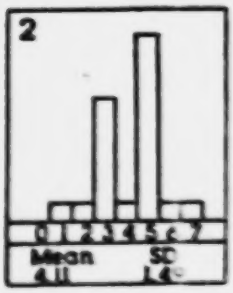


LONG TERM RISK

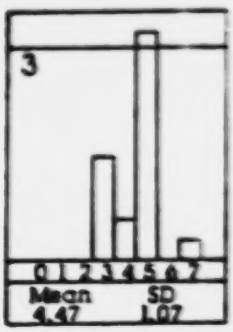
Moderate



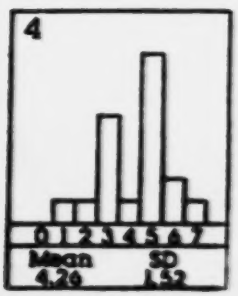
19-year-old male found by roommate in a "sluggish" state following the ingestion of 10 sleeping pills (Sominex) and 1 bottle of whiskey. Recently has been giving away his possessions and has written a suicide note. After being brought to the Emergency Room, declares that he will do it again. Blood alcohol level .23. For the last 3 or 4 weeks there has been sleep and appetite disturbance, with a 15-pound weight loss and subjective feelings of depression. Diagnostic impression: adjustment disorder with depressed mood versus major depressive episode. Patient refused hospitalization.



23-year-old male brought to CIC by ambulance. Following a fight with his girlfriend, felt like shooting himself but does not have a gun. Recent sleep and appetite disturbance and a tendency to get into fights because he feels that everyone is against him (is being accused of stealing and molesting children, both of which he denies). Patient recently released from prison for robbery. In CIC is described as paranoid, hearing voices, suffering from mild depression; there is a hysteroid quality to his presentation. Diagnostic impression: personality disorder with questionable affective disorder. History reveals 5 suicide "gestures" in the past (with other people being present during them) and a psychiatric hospitalization 7 years ago.



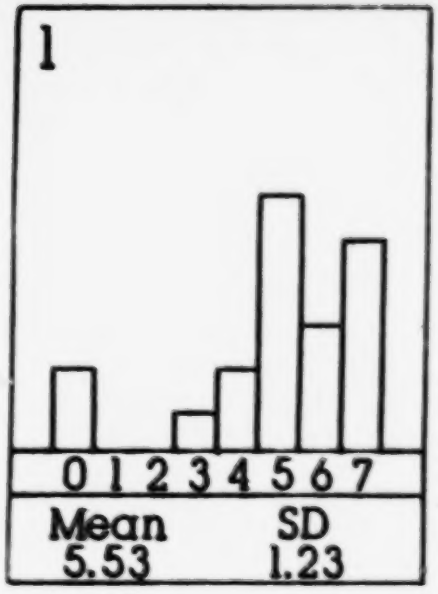
16-year-old female brought by mother because she is feeling suicidal and "out of control." Patient tearful, complains of difficulties with concentration, sleep, and appetite disturbance. Is scared, helpless, and is falling behind in school. Last night while driving on the freeway swerved towards a truck, wanting to hit it. Recent stresses include her boyfriend committing suicide 3 months ago and discovering that she has mononucleosis. Reports chronic suicidal ideation through adolescence, once cut her wrists superficially while in the 6th grade. Had many discussions about suicide with her deceased boyfriend. Uses marijuana every weekend and episodically during the week; uses other drugs as well.

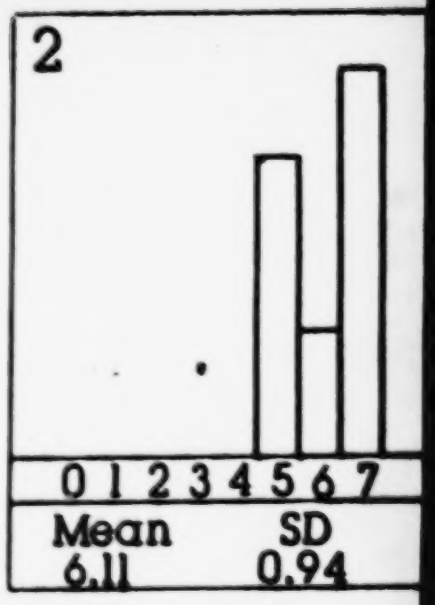


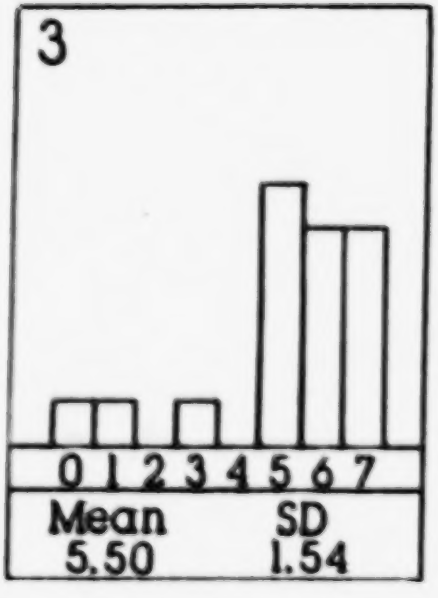
24-year-old male referred by his therapist. States "I am really feeling suicidal now." His request for admission was turned down by a private hospital because he was felt to be manipulative. Also, a previous admission at that hospital lasted only 3 days and was not felt to be helpful. Currently symptoms include loss of appetite and somnolence. Patient feels that he cannot control his suicidal impulse to overdose or hang himself. His self-esteem has suffered following a recent break up with his girlfriend, with whom he has had an on-and-off relationship for some time. Another stress is patient's chronic job instability. There is a history of a learning disorder and several overdoses, one of which was with Valium and alcohol, requiring hospitalization. There is also a history of heavy binge drinking, but patient is currently abstinent. Is in treatment with a therapist and with a psychiatrist. In the interview is vague, focuses on his girlfriend and how to get her back. Has serious doubts that she will return. Diagnostic impression: adjustment disorder with depressed and anxious mood.

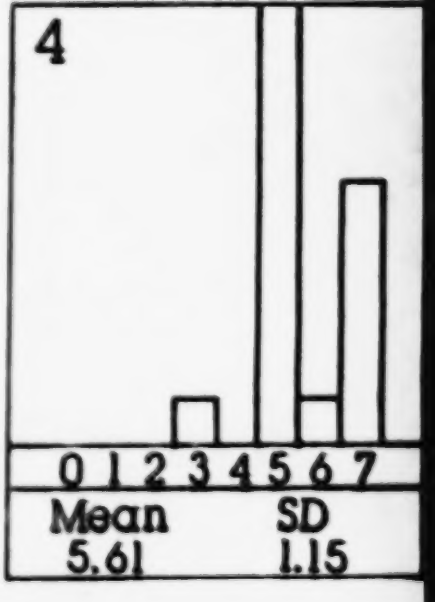
LONG TERM RISK

High

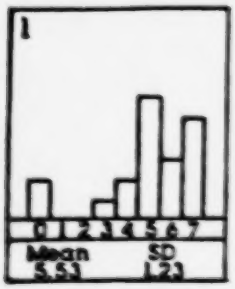




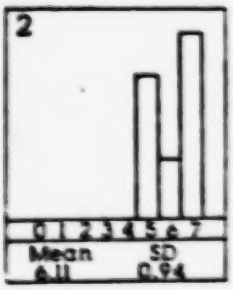




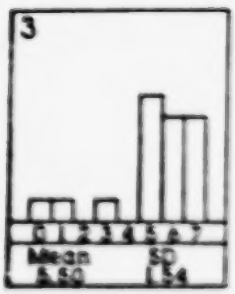
LONG TERM RISK — High



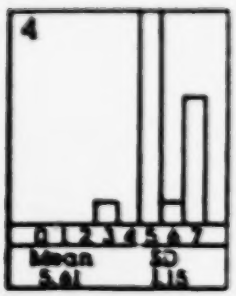
27-year-old male brought by his mother. Intoxicated. Wants to die, shows a scar on his wrist from suicide attempt a few months ago. Eleven days ago put gun to his and his girlfriend's head. Most recent stressor is wife leaving 2 weeks ago. Has $130 a day cocaine habit and also abuses alcohol. Although he maintains that he has been seeing a chemical dependency counselor for 9 weeks, independent information does not confirm this claim.



30-year-old male brought from his place of employment by a personnel representative. Patient has been thinking of suicide "all the time" because he "can't cope." Has a knot in his stomach, sleep and appetite are down (sleeps only 3 hours per night), and plans to either shoot himself, jump off a bridge, or drive recklessly. Precipitant: constant fighting with his wife leading to a recent break up (there is a long history of mutual verbal/physical abuse). There is a history of a serious suicide attempt: patient jumped off a ledge and fractured both legs; the precipitant for that attempt was a previous divorce. There is a history of chemical dependency with 2 courses of treatment. There is no current problem with alcohol or drugs. Patient is tearful, shaking, frightened, feeling hopeless, and at high risk for impulsive acting out. He states that life isn't worthwhile.



32-year-old male referred from the Emergency Department. Patient was in the process of overdosing when he was called by a friend who arranged for the ambulance to bring the patient to CIC. The patient took 72 over-the-counter sleeping pills and 10 or 15 aspirin tablets. Patient wrote a long suicide note bequeathing belongings, expressing guilt about not doing well on his job, feeling hopless about a "hereditary thinking disorder." Feels that no one can help him, suffers from low self-esteem ("I'm a misfit"). Three nights ago made a suicide attempt with Navane and aspirin, but woke up by himself in the morning. Lives by himself. No obvious immediate precipitant, but the patient's mother died 6 months ago. Currently in therapy and also has a psychiatrist.



30-year-old female, chronic schizophrenic, self-referred. For 3 weeks has been sleeping only 4 hours per night and has thought of suicide every day. Reports paranoid ideas and racing thoughts, life appears quite disorganized. This morning was planning to swallow some pills (unspecified). Currently in treatment with a psychiatrist. Made a serious suicide attempt 4 years ago (jumped from a bridge, resulting in a broken pelvis). Many previous psychiatric hospitalizations, the most recent one 2 years ago. History of marijuana use but is currently drug-free. In the interview, is cooperative, tearful, labile, and feeling very hopeless.